5. Exemplary Damages in the amount of five-hundred and fifty thousand dollars ($550,000) from each Defendant to PLAINTIFF as an enhancement of compensatory damages because of the maliciousness, wanton, reckless, and oppressive character of the acts described herein, and to punish and deter other state employees acting under color of law from committing these or similar acts.

6. Mental Anguish Damages in the amount of five-hundred and fifty thousand dollars ($550,000) from each Defendant to PLAINTIFF for mental suffering resulting from the events set forth herein.

7. Nominal Damages in the amount of five-hundred and fifty thousand dollars ($550,000) from each Defendant to PLAINTIFF which PLAINTIFF is entitled to because the law may infer the damages from the breach of an agreement or the invasion of a Constitutional right in light of the facts described herein.

8. Punitive Damages in the amount of five-hundred and fifty thousand dollars ($550,000) from each Defendant to PLAINTIFF as an enhancement of compensatory damages because of the maliciousness, wanton, reckless, and oppressive character of the acts described herein, and to punish and deter other state employees acting under color of law from committing these or similar acts.

9. Appointment of Counsel as PLAINTIFF is a layperson and unskilled at law and was compelled to seek the assistance from a fellow prisoner (William Milton, CDCR# P-38650, who is also a layperson and unskilled at law), to assist in drafting, filing and prosecuting the instant complaint in this Court.

10. Economic and non-economic Damages.

11. Medical and Related Expenses, according to proof.

12. Lost Earnings, past and future.

13. Costs of Suit incurred herein.

14. Interest, as allowed by law.

15. Attorney's Fees and Costs

16. An order directing the U.S. Marshal to serve the named-Defendants including waiver of any and all processing/service and additional fees.

17. Other such and further relief as the Court may deem proper.

VERIFICATION

Pursuant to 28 U.S.C. §1746, I, Joel Nunez, read the foregoing Civil Rights complaint and declare under penalty of perjury that all statements made herein are true and correct to the best of my knowledge, information and belief.

Signature of Declarant: Joel Nunez

0506200

STATE OF CALIFORNIA
CDC 7362 (Rev. 03/04)

HEALTH CARE SERVICES REQUEST FORM

DEPARTMENT OF CORRECTIONS

PART I: TO BE COMPLETED BY THE PATIENT

A fee of $5.00 may be charged to your trust account for each health care visit.

If you believe this is an urgent/emergent health care need, contact the correctional officer on duty.

REQUEST FOR: MEDICAL ☑ MENTAL HEALTH ☐ DENTAL ☐ MEDICATION REFILL ☐

NAME	CDC NUMBER	HOUSING
Nunez, Joel	K. 63350	EW. 319 up
PATIENT SIGNATURE		DATE
Joel Nunez.		10-19-15

REASON YOU ARE REQUESTING HEALTH CARE SERVICES. (Describe Your Health Problem And How Long You Have Had The Problem) I have chest pain. my ~~to~~ left ~~arm~~ Leg I feel numb.

I need to see DR. please.

NOTE: IF THE PATIENT IS UNABLE TO COMPLETE THE FORM, A HEALTH CARE STAFF MEMBER SHALL COMPLETE THE FORM ON BEHALF OF THE PATIENT AND DATE AND SIGN THE FORM

PART III: TO BE COMPLETED AFTER PATIENT'S APPOINTMENT

☒ Visit is not exempt from $5.00 copayment. (Send pink copy to Inmate Trust Office.)

PART II: TO BE COMPLETED BY THE TRIAGE REGISTERED NURSE

Date / Time Received: 10-22-15 0745 **Received by:** James A Kinney Jr RN

Date / Time Reviewed by RN: **Reviewed by:** James Kinney Jr

S: Pain Scale: 1 2 3 4N 5 6 7 8 9 10

RECEIVED
OCT 28 2015
MEDICAL RECORDS

O: T: P: R: BP: WEIGHT:

A:

P: RN line

☑ See Nursing Encounter Form Chest Pain (chest wall pain)

1. Disability Code	2. Accommodation	3. Effective Communication
☐ TABE Score≤ 4.0	☐ Additional Time	☐ P/I asked questions
☐ DPH ☐ DPV ☐ LD	☐ Equipment ☐ SLI	☐ P/I summed information
☐ DPS ☐ DNH	☐ Louder ☐ Slower	Please check one:
☐ DNS ☐ DDP	☐ Basic ☐ Transcribe	☐ Not Reached* ☐ Reached
☐ Not Applicable	☐ Other	*See Chrono/Notes
4.Comments		

E:

APPOINTMENT SCHEDULED AS: EMERGENCY (IMMEDIATELY) ☐ URGENT (WITHIN 24 HOURS) ☐ ROUTINE (WITHIN 14 CALENDAR DAYS) ☑

REFERRED TO PCP: Dr Lam | DATE OF APPOINTMENT: per scheduler

COMPLETED BY: James A Kinney Jr RN | NAME OF INSTITUTION: CTF-C

PRINT/STAMP NAME: James Kinney Jr. RN | SIGNATURE / TITLE: James A Kinney Jr RN | DATE/TIME COMPLETED: 10-22-15 1105

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A1

1617526

STATE OF CALIFORNIA
CDC 7362 (Rev. 03/04)

HEALTH CARE SERVICES REQUEST FORM

DEPARTMENT OF CORRECTIONS

PART I: TO BE COMPLETED BY THE PATIENT

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If you believe this is an urgent/emergent health care need, contact the correctional officer on duty.

REQUEST FOR: MEDICAL ☑ MENTAL HEALTH ☐ DENTAL ☐ MEDICATION REFILL ☐

NAME	CDC NUMBER	HOUSING
NUNEZ, JOEL	K-63350	EW-319 UP
PATIENT SIGNATURE: Joel Nunez		DATE: 1-9-15

REASON YOU ARE REQUESTING HEALTH CARE SERVICES. (Describe Your Health Problem And How Long You Have Had The Problem)

I need to see eyes DR. MY PRESCRIPSION GLASSES, ARE TO OLD & have SCRACHES on the Mirros. Need New pair of glasses.

NOTE: IF THE PATIENT IS UNABLE TO COMPLETE THE FORM, A HEALTH CARE STAFF MEMBER SHALL COMPLETE THE FORM ON BEHALF OF THE PATIENT AND DATE AND SIGN THE FORM

RECEIVED
JAN 23 2015
MEDICAL RECORDS

PART III: TO BE COMPLETED AFTER PATIENT'S APPOINTMENT

☐ Visit is not exempt from $5.00 copayment. (Send pink copy to Inmate Trust Office.)

PART II: TO BE COMPLETED BY THE TRIAGE REGISTERED NURSE

Date / Time Received:	1/17/15	**Received by:**	Augusta Coleman
Date / Time Reviewed by RN:	@ 0035	**Reviewed by:**	RN

S: "I need a new pair of eyeglass" Pain Scale: 1 2 3 4 5 6 7 8 9 10

asymptomatic

O: T: 97.8 P: 84 R: 18 BP: 116/78 WEIGHT: 210 # 99% ra

A/O x4. VSS. Pt wearing prescription eye glass c̄ a lot of scratches; the lenses quality deteriorating

A:

P: PCP RN — will generate new PPS attached for PCP to consult

☐ **See Nursing Encounter Form**

E:

1. Disability Code:
☐ TABE score ≤ 4.0
☐ DPH ☐ DPV ☐ LD
☐ DPS ☐ DNH
☐ DNS ☐ DDP

2. Accommodation:
☐ Additional time
☐ Equipment ☐ SLI
☐ Louder ☐ Slower
☑ Basic ☐ Transcribe
☐ Other*

3. Effective Communication:
☑ P/I asked questions
☐ P/I summed information
Please check one:
☐ Not reached* ☑ Reached
*See chrono/notes

4. Comments: N/A TABE: 10.8

FSP41-0040 (Rev.1/12)

APPOINTMENT SCHEDULED AS:	EMERGENCY (IMMEDIATELY) ☐	URGENT (WITHIN 24 HOURS) ☐	ROUTINE (WITHIN 14 CALENDAR DAYS) ☐

REFERRED TO PCP: N	DATE OF APPOINTMENT:
COMPLETED BY: J. Estamo RN CTF Soledad	NAME OF INSTITUTION: CTF

PRINT / STAMP NAME	SIGNATURE / TITLE	DATE/TIME COMPLETED
	[signature]	JAN 22 2015 1239

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STATE OF CALIFORNIA
CDC 7362 (Rev. 03/04)

HEALTH CARE SERVICES REQUEST FORM

DEPARTMENT OF CORRECTIONS

PART I: TO BE COMPLETED BY THE PATIENT

A fee of $5.00 may be charged to your trust account for each health care visit.

If you believe this is an urgent/emergent health care need, contact the correctional officer on duty.

REQUEST FOR: MEDICAL ☑ MENTAL HEALTH ☐ DENTAL ☐ MEDICATION REFILL ☐

NAME	CDC NUMBER	HOUSING
NUÑEZ, Joel	K-63350.	EW 319 UP
PATIENT SIGNATURE		DATE
Joel Nuñez		4-10-14

REASON YOU ARE REQUESTING HEALTH CARE SERVICES. (Describe Your Health Problem And How Long You Have Had The Problem) I am requested to see Eye Doctor. My prescripsion Glases, need to be renew.

RECEIVED APR 15 2014 By

RECEIVED APR 15 2014 By

NOTE: IF THE PATIENT IS UNABLE TO COMPLETE THE FORM, A HEALTH CARE STAFF MEMBER SHALL COMPLETE THE FORM ON BEHALF OF THE PATIENT AND DATE AND SIGN THE FORM

PART III: TO BE COMPLETED AFTER PATIENT'S APPOINTMENT

☐ Visit is not exempt from $5.00 copayment. (Send pink copy to Inmate Trust Office.)

PART II: TO BE COMPLETED BY THE TRIAGE REGISTERED NURSE

Date / Time Received: 4/14/14 @ 0712	**Received by:** [illegible]
Date / Time Reviewed by RN:	**Reviewed by:** [illegible]

S: Last eye test 7/8/13, received glasses 8/15/13 — Pain Scale: ~~1 2 3 4 5 6 7 8 9 10~~

"my eyeglasses has scratches that bothers me from seeing clearly with it."

4 Ⓛ - 20/70 ; 7 | 20/25 ē
6 Ⓡ - 20/30 glasses 7 | 20/25 glasses
3 Ⓒ - 20/70 ; 5 | 20/40

Yeglasses [illegible] 5/23/13 [illegible] eye drops PRN

O: T: 98.2 P: 70 R: 20 BP: 129/73 WEIGHT: 208 lbs.

pt. a & o x3. ambulatory ē steady gait, c/o scratches to eye glasses bothering him ē his vision. Eyes PERLA, ø redness.

A: alt in sensory perception vision R/T eyeglasses ē scratches

P: RFS optometry initiated.

☐ **See Nursing Encounter Form** pt made aware of RFS process & waiting period to eye clinic

E: pt. verbalized understanding

1. Disability Code:	2. Accommodation:	3. Effective Communication:
☑ TABE score ≤ 4.0	☐ Additional time	☑ P/I asked questions
☐ DPH ☐ DPV ☐ LD	☐ Equipment ☐ SLI	☑ P/I summed information
☐ DPS ☐ DNH	☐ Louder ☐ Slower	Please check one:
☐ DNS ☐ DDP	☐ Basic ☐ Transcribe	☐ Not reached* ☑ Reached
	☐ Other*	*See chrono/notes

4. Comments: [illegible]

FSP41-0040 (Rev.1/12)

APPOINTMENT SCHEDULED AS:	EMERGENCY (IMMEDIATELY) ☐	URGENT (WITHIN 24 HOURS) ☐	ROUTINE (WITHIN 14 CALENDAR DAYS) ☐
REFERRED TO PCP: NLA		DATE OF APPOINTMENT: N/A	
COMPLETED BY		NAME OF INSTITUTION CTF	
PRINT / STAMP NAME B. RAGASA RN CTF SOLEDAD	SIGNATURE / TITLE [signature]	DATE/TIME COMPLETED 4/15/14 @ 1240	

MDL

0516988

STATE OF CALIFORNIA
CDC 7362 (Rev. 03/04)

HEALTH CARE SERVICES REQUEST FORM

DEPARTMENT OF CORRECTIONS

PART I: TO BE COMPLETED BY THE PATIENT

A fee of $5.00 may be charged to your trust account for each health care visit.

If you believe this is an urgent/emergent health care need, contact the correctional officer on duty.

REQUEST FOR: MEDICAL ☑ MENTAL HEALTH ☐ DENTAL ☐ MEDICATION REFILL ☐

NAME	CDC NUMBER	HOUSING
Nuñez, Joel	K-63350	EW-319 UP
PATIENT SIGNATURE: Joel Nunez		DATE: 2-24-14

REASON YOU ARE REQUESTING HEALTH CARE SERVICES. (Describe Your Health Problem And How Long You Have Had The Problem)

Need to see DR. I HAVE Knee problem & swalled afent I walk for a period of time.

NOTE: IF THE PATIENT IS UNABLE TO COMPLETE THE FORM, A HEALTH CARE STAFF MEMBER SHALL COMPLETE THE FORM ON BEHALF OF THE PATIENT AND DATE AND SIGN THE FORM

RECEIVED MAR 0 5 2014

PART III: TO BE COMPLETED AFTER PATIENT'S APPOINTMENT

☒ Visit is not exempt from $5.00 copayment. (Send pink copy to Inmate Trust Office.)

PART II: TO BE COMPLETED BY THE TRIAGE REGISTERED NURSE

Date / Time Received: 3/4/14 @ 0730 — Received by: [illegible]
Date / Time Reviewed by RN: — Reviewed by: [illegible]

S: "Knee is swollen when I walk a lot. I want to see the doctor to do xray on my R leg." Pain Scale: 0 1 2 3 4 5 6 7 8 9 10

A: NKA — P ø
M: allo-chor, miconazole, liquitears; chronic Hep. C=stage I A ø
P: Lumbar pain - chronic, coccidiodiomycosis, cataracts Bilat. Eye, Pterygium ø
L: breakfast — N ø
E: IPC/O swollen (R) leg when he ambulates sometimes

O: T: 97.8 P: 60 R: 18 BP: 128/67 WEIGHT: 205 lbs. Sats = 99% RA
IPC/O that his right knee swells up sometimes when he ambulates. OE right knee skin warm, dry & intact ø swelling, ø redness, CMST good. pulses strong. He ambulates well c̄ steady gait. Full ROM noted ø pain

A: Altered level of comfort RT evidenced C/O (R) knee swells up sometimes

P: MDL; to alleviate discomfort advised IP to on ambulation.

☐ See Nursing Encounter Form — elevate bilat lower extremities s/p ambulation if he noted swelling or sx again to report immediately to staff.

E: IP verbalizes understanding

1. Disability Code:
☐ TABE score ≤ 4.0
☐ DPH ☑ DPV ☐ LD
☐ DPS ☐ DNH
☐ DNS ☐ DDP — N/A

2. Accommodation:
☐ Additional time
☐ Equipment ☐ SLI
☐ Louder ☐ Slower
☑ Basic ☐ Transcribe
☐ Other

3. Effective Communication:
☑ P/I asked questions
☑ P/I summed information
Please check one:
☐ Not reached* ☑ Reached
*See chrono/notes

4. Comments: Tabe: 5.1

FSP41-0040 (Rev.1/12)

APPOINTMENT SCHEDULED AS:	EMERGENCY (IMMEDIATELY) ☐	URGENT (WITHIN 24 HOURS) ☐	ROUTINE (WITHIN 14 CALENDAR DAYS) ☐
REFERRED TO PCP: yes		DATE OF APPOINTMENT: as per schedule	
COMPLETED BY: Chona Alfafara Contos RN		NAME OF INSTITUTION: CTF	
PRINT / STAMP NAME	SIGNATURE / TITLE: Chona Alfafara Contos RN	DATE/TIME COMPLETED: 03-5-14 @ 1112hrs	

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RECEIVED
JAN 16 2013

9835298

STATE OF CALIFORNIA
CDC 7362 (Rev. 03/04)

HEALTH CARE SERVICES REQUEST FORM

DEPARTMENT OF CORRECTIONS

PART I: TO BE COMPLETED BY THE PATIENT

A fee of $5.00 may be charged to your trust account for each health care visit.

If you believe this is an urgent/emergent health care need, contact the correctional officer on duty.

REQUEST FOR: MEDICAL ☐ MENTAL HEALTH ☐ DENTAL ☐ MEDICATION REFILL ☐

NAME	CDC NUMBER	HOUSING
NUNEZ, JOEL	K-63350	EW-211 UP
PATIENT SIGNATURE: Joel Nunez		DATE: 1-9-2013

REASON YOU ARE REQUESTING HEALTH CARE SERVICES. (Describe Your Health Problem And How Long You Have Had The Problem) I need to see the eye Doctor. My eyes CLASES ARE To old and have scrach and falling apart. need new prescripcion. I am blind from my left eye.

NOTE: IF THE PATIENT IS UNABLE TO COMPLETE THE FORM, A HEALTH CARE STAFF MEMBER SHALL COMPLETE THE FORM ON BEHALF OF THE PATIENT AND DATE AND SIGN THE FORM

PART III: TO BE COMPLETED AFTER PATIENT'S APPOINTMENT

☐ Visit is not exempt from $5.00 copayment. (Send pink copy to Inmate Trust Office.)

PART II: TO BE COMPLETED BY THE TRIAGE REGISTERED NURSE

Date / Time Received: 1/11/13 @
Date / Time Reviewed by RN: 0720
Received by: R. De Luna RN
Reviewed by: CTF Soledad

S: c/o ↓ visual acuity
Pain Scale: 1 2 3 4 5 6 7 8 9 10

NKDA. ø current meds. Hx cataract surgery on OS. Denies blurry vision ø this time. Stated "I haven't seen the eye doctor in > 2 yrs."

O: T: 97.8 P: 67 R: 18 BP: 110/65 WEIGHT: 198# O2Sat 98% RA

AxOx3. ø acute distress. Snellen's test OD-20/40, OS-20/50 ø glasses

Ambulates ē steady gait.

A: alteration in sensory perception. R/T ↓ visual acuity

P: RHL-To obtain optometry consult from PCP.

☐ See Nursing Encounter Form

E: Discussed plan of care to pt. Verbalized understanding

1. Disability Code:
☐ TABE score ≤ 4.0
☐ DPH ☐ DPV ☐ LD
☐ DPS ☐ DNH
☐ DNS ☐ DDP

2. Accommodation:
☐ Additional time
☐ Equipment ☐ SLI
☐ Louder ☐ Slower
☒ Basic ☐ Transcribe
☐ Other*

3. Effective Communication:
☒ P/I asked questions
☒ P/I summed information
Please check one:
☐ Not reached* ☒ Reached
*See chrono/notes

4. Comments: TABE 5.9

FSP41-0040 (Rev.1/12)

APPOINTMENT SCHEDULED AS:	EMERGENCY (IMMEDIATELY) ☐	URGENT (WITHIN 24 HOURS) ☐	ROUTINE (WITHIN 14 CALENDAR DAYS) ☒
REFERRED TO PCP: yes		DATE OF APPOINTMENT: routine	
COMPLETED BY		NAME OF INSTITUTION: CTF-C	
PRINT / STAMP NAME: R. De Luna RN CTF Soledad	SIGNATURE / TITLE: RDeLuna RN	DATE/TIME COMPLETED: 1/14/13 @ 1130	

SECOND REQUEST TO SEE DR

9982694

STATE OF CALIFORNIA
CDC 7362 (Rev. 03/04)

HEALTH CARE SERVICES REQUEST FORM

DEPARTMENT OF CORRECTIONS

PART I: TO BE COMPLETED BY THE PATIENT

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If you believe this is an urgent/emergent health care need, contact the correctional officer on duty.

REQUEST FOR: MEDICAL ☒ MENTAL HEALTH ☐ DENTAL ☐ MEDICATION REFILL ☐

NAME	CDC NUMBER	HOUSING
NÚÑEZ, JOEL	K-63350	F-W-321 LP
PATIENT SIGNATURE: Joel Núñez		DATE: 3-9-11

REASON YOU ARE REQUESTING HEALTH CARE SERVICES. (Describe Your Health Problem And How Long You Have Had The Problem) I NEED TO SEE THE DOCTOR. I HAVE ACTRITIS IN MY LOWER BACK. AND I HAVE A LOT OF pain. THE MEDICATION HE PRESCRIBME IS NOT WORKING

NOTE: IF THE PATIENT IS UNABLE TO COMPLETE THE FORM, A HEALTH CARE STAFF MEMBER SHALL COMPLETE THE FORM ON BEHALF OF THE PATIENT AND DATE AND SIGN THE FORM

PART III: TO BE COMPLETED AFTER PATIENT'S APPOINTMENT

☐ Visit is not exempt from $5.00 copayment. (Send pink copy to Inmate Trust Office.)

PART II: TO BE COMPLETED BY THE TRIAGE REGISTERED NURSE

Date / Time Received:	3/15/11	**Received by:**	[signature]
Date / Time Reviewed by RN:		**Reviewed by:**	

S: Pain Scale: 1 2 3 4 5 (6) 7 8 9 10

Naproxen and tylenol ~~#3~~ are not working. I still have pain on my (R) knee / leg. the Naproxen helps swelling sometime

O: (T): 98 P: 71 R: 20 BP: 105/59 WEIGHT: 189 lbs

Ø swelling on (R) knee @ this time, gait steady full ROM, able to move affected area

A: Alteration in comfort RT Back (R) knee pain

P: Referred to PCP line

☐ See Nursing Encounter Form

Pt verbalized the instructions to continue to take pain medications until seen by PCP.

E:

APPOINTMENT SCHEDULED AS:	EMERGENCY (IMMEDIATELY) ☐	URGENT (WITHIN 24 HOURS) ☐	ROUTINE (WITHIN 14 CALENDAR DAYS) ☐
REFERRED TO PCP:		DATE OF APPOINTMENT:	
COMPLETED BY: [signature]		NAME OF INSTITUTION: CTF	
PRINT / STAMP NAME: [signature]	SIGNATURE / TITLE: [signature]		DATE/TIME COMPLETED: 3/15/11

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STATE OF CALIFORNIA
CDC 7362 (Rev. 03/04)

HEALTH CARE SERVICES REQUEST FORM

DEPARTMENT OF CORRECTIONS

PART I: TO BE COMPLETED BY THE PATIENT

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If you believe this is an urgent/emergent health care need, contact the correctional officer on duty.

REQUEST FOR: MEDICAL ☐ MENTAL HEALTH ☐ DENTAL ☐ MEDICATION REFILL ☐

NAME	CDC NUMBER	HOUSING
NUNEZ, Joel	K-63350	Y-W-120 UP
PATIENT SIGNATURE: Joel Nunez		DATE: 1-30-11

REASON YOU ARE REQUESTING HEALTH CARE SERVICES. (Describe Your Health Problem And How Long You Have Had The Problem) I need to See the DOCTOR, The medication he prescribe me, Is not working. I am in pain at this moment, I have actritis in my left spine and Knee pain, very Sharp pain Also having Cold Symptoms

NOTE: IF THE PATIENT IS UNABLE TO COMPLETE THE FORM, A HEALTH CARE STAFF MEMBER SHALL COMPLETE THE FORM ON BEHALF OF THE PATIENT AND DATE AND SIGN THE FORM

PART III: TO BE COMPLETED AFTER PATIENT'S APPOINTMENT

☒ Visit is not exempt from $5.00 copayment. (Send pink copy to Inmate Trust Office.)

PART II: TO BE COMPLETED BY THE TRIAGE REGISTERED NURSE

Date / Time Received: Received by: 2/1/11

Date / Time Reviewed by RN: [signature] Reviewed by: 2/1/11

Pain Scale: 1 2 3 4 5 6 7 8 9 10

S: (L) Knee pain / cold symptoms

O: T: 98 P: 64 R: 20 BP: 120/68 WEIGHT: ~~145~~ 194 lbs
(L) Knee shows no swelling

A: Alteration in comfort r/t (L) Knee discomfort.

P:

☐ See Nursing Encounter Form
Was on Tramadol and has worked for him -

E: Pt report to be on tramadol

APPOINTMENT SCHEDULED AS:	EMERGENCY (IMMEDIATELY) ☐	URGENT (WITHIN 24 HOURS) ☐	ROUTINE (WITHIN 14 CALENDAR DAYS) ☐
REFERRED TO PCP:		DATE OF APPOINTMENT:	
COMPLETED BY: [signature]		NAME OF INSTITUTION: CTF	
PRINT/STAMP NAME: D. Dall	SIGNATURE/TITLE: [signature]		DATE/TIME COMPLETED: 2/2/11

Ned Arrival Pleasant Valley 961212

STATE OF CALIFORNIA
CDC 7362 (Rev. 03/04)

HEALTH CARE SERVICES REQUEST FORM

DEPARTMENT OF CORRECTIONS

PART I: TO BE COMPLETED BY THE PATIENT

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If you believe this is an urgent/emergent health care need, contact the correctional officer on duty.

REQUEST FOR: MEDICAL ☑ MENTAL HEALTH ☐ DENTAL ☐ MEDICATION REFILL ☐

NAME	CDC NUMBER	HOUSING
NÚÑEZ, JOEL	K-63350	Y-W-120 UP
PATIENT SIGNATURE: Joel Nuñez		DATE: 12-16-10

REASON YOU ARE REQUESTING HEALTH CARE SERVICES. (Describe Your Health Problem And How Long You Have Had The Problem) I need to SEE The DOCTOR. I HAVE ACTRITIS IN MY SPINE. LOWER BACK PAIN. ALSO I HAVE COLD Symtoms. Thanch you.

NOTE: IF THE PATIENT IS UNABLE TO COMPLETE THE FORM, A HEALTH CARE STAFF MEMBER SHALL COMPLETE THE FORM ON BEHALF OF THE PATIENT AND DATE AND SIGN THE FORM

PART III: TO BE COMPLETED AFTER PATIENT'S APPOINTMENT

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PART II: TO BE COMPLETED BY THE TRIAGE REGISTERED NURSE

Date / Time Received: **Received by:**

Date / Time Reviewed by RN: 12/17/10 **Reviewed by:** [illegible]

S: Pain Scale: 1 2 3 4 5 6 7 8 (9) 10

I was on Tramadol when I was in Pleasant Valley, it was discontinued and I 602 the doctor. I am also having Running Nose Sore Throat.

O: 99 T: 98 P: 76 R: 20 BP: 124/76 WEIGHT: 190 lbs.
Rated pain 9/10 to the back. Able to ambulate w/o difficulty.

A: Impaired comfort r/t Back discomfort

P: MD to evaluate Back pain

☐ **See Nursing Encounter Form**

Encourage oral fluid intake. Back stretch exercise. Pamphlet given.

E:

DECEIVED DEC 20 2010 By

APPOINTMENT SCHEDULED AS:	EMERGENCY (IMMEDIATELY) ☐	URGENT (WITHIN 24 HOURS) ☐	ROUTINE (WITHIN 14 CALENDAR DAYS) ☐
REFERRED TO PCP:		DATE OF APPOINTMENT:	
COMPLETED BY: [illegible] RN		NAME OF INSTITUTION: CTF-Soledad	
PRINT / STAMP NAME: [illegible]	SIGNATURE / TITLE: [illegible]		DATE/TIME COMPLETED: 12/20/10

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